

HEALTH CARE PLAN



Eastern Illinois Area of Special Education
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Charleston, IL 61920
Phone: 217/348-7700
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Date of Conference: _____

- Review of Existing Data Reevaluation IEP Review/Revision Manifestation Determination Termination of Placement
 Initial Eligibility Initial IEP Transition Graduation Other _____

Student Name: _____

Date of Birth: _____

Health Care Issues:

Health Care Services Required: Yes No

Service Provider(s): _____

Type/Nature of Service:

Projected Minutes/Week: _____

Anticipated Duration: _____

Frequency: _____

Initiation Date: _____

December 2007